GatorCare
Your Partner in Health

GatorCare Genetic Testing Request

Patient Name: **Patient DOB:**	**HCCID #:** **Subscriber Name:** **Subscriber DOB:** **Phone #:**

Requested Test Name:

Prevention

CPT CODE(S):

Genetics Test Code:

ICD 10 CODE(S):

Test description (including documentation):

Specificity of test:

Sensitivity of test:

Requested by: **Address:**	**Contact Person:** **Phone #:**

Major Clinical Features:

Previous pertinent lab studies/diagnostic investigations:

Level of actionable consequences of testing:

☐ Genetic Counseling for future children in family

☐ Medical monitoring changes

☐ Treatment considerations

☐ Life altering changes

☐ Approved ☐ Denied

Comments/Notes:

Signature: _____ Date: _____

Please submit completed form to Heather Stalker - ***Email***: stalkhj@peds.ufl.edu or ***Fax***: 352-294-8058